WASHINGTON STUDENT ACHIEVEMENT COUNCIL
EDUCATION · OPPORTUNITY · RESULTS

WASHINGTON STATE HEALTH PROFESSIONAL

SCHOLARSHIP PROGRAM

Quarterly Service Confirmation Form

Do not leave blanks. Submit form **on or after** last day of quarter.

SCHOLARSHIP RECIPIENT

2016 Quarter: ☐ Jan–Mar ☐ Apr–Jun ☐ Jul-Sep ☐ Oct-Dec

Name:

Address:

City: **State:** **Zip**

Email:

Best Phone Number:

I certify that: I am providing primary care at an eligible facility that meets program requirements as described on the Washington Health Professional Shortage Areas Listing and on the Promissory Note that I signed.

Signature:_____

Date:_____

DEFINITION OF
"FULL TIME EMPLOYMENT"

Definition of "full time" employment:
For all health professionals, *At least 32 hours of the minimum 40 hours per week are/will be spent providing direct outpatient care during normally scheduled clinic hours at an approved & eligible site as described on the Washington Health Professional Shortage Areas Listing. The remaining 8 hours per week is/will be spent providing clinical services to patients performing clinical support activities in alternate locations as directed by the site(s), or performing practice-related administrative activities.*

For part time, at least 20 hours of the minimum 24 hours per week are/will be spent providing direct outpatient care during normally scheduled clinic hours at an approved and eligible site as described above for full time employment.

PROGRAM INFORMATION

- If this is a new employer you must submit a job description.
- Form is due in our office no later than 14 days after the end of the quarter.
- Employer must retain the original copy of the form.
- See Instructions on how to complete this form

EMPLOYER SECTION

Site Name:

Address:

City: **Zip:**

I have reviewed the hours worked and certify that the scholarship recipient*: (check all that apply):*

Was employed at this facility for the quarter indicated and **WORKED:**

☐ **Full time** - a minimum of 40 hours per week

☐ **Less than 40 hours per week, but a minimum of 24 hours per week**

☐ **Actual hours worked this quarter.**

(Include all paid hours – do not include on-call or overtime hours. Also use this box to fill in hours if submitting as the final form before the end of the quarter or if participant was on extended leave.

☐ Is/was on extended leave from _____ to _____ due to _____.
(please indicate the reason for the extended leave)

Paid Leave Hours: ____ Unpaid Leave Hours: ____

I have read and understand the "Instructions" on completing this form and certify that this facility meets the requirements of the program and the above recipient is working in an eligible position.

The certifications and information provided above are true, accurate and complete to the best of my knowledge and belief. I have read and understand the definition of "full time" employment.

Signature:

Printed Name:

Title:

Date:

Phone Number:

Email:

Site administrator (not the recipient) may mail, fax, or scan and email a copy of the service form to:

Mailing address: WSAC/HEALTH
PO Box 4340 Olympia WA 98504-3430

Fax: 360- 704-6242

Email: health@wsac.wa.gov **Phone:** 360-753-7794